

Group Insurance

Please send the completed form and all attachments to:

The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19101

Group Life Insurance Claim Form (Use for employee/member and dependent death claims)

How to complete and submit a Group Life Insurance Claim Form

1. Complete Sections 1, 2, 3, 4, and 5 of the Group Contract Holder Statement portion of the Group Life Insurance Claim Form. Section 1 must be completed if the claim is for an employee/member, or for a dependent of an employee. Please be sure to complete the "Relationship to Employee" block.

For Dependent Term Life coverage on children, the employee is always the beneficiary. For Dependent Term Life coverage on spouses, the employee is usually the beneficiary, except for certain Group Universal Life and Group Variable Universal Life coverage, in which the employee may be able to specify other beneficiaries.

2. Detach the Beneficiary Statement* and give a copy to each beneficiary. Ask each beneficiary to complete it and return it to you.

If there are multiple beneficiaries, each beneficiary should complete this form. It is only necessary for you to submit one Group Contract Holder Statement, regardless of the number of Beneficiary Statements completed. If you have difficulty obtaining forms from all beneficiaries, please submit the information you have.

*If the beneficiary is an estate, a minor, or not competent to handle financial affairs, the Beneficiary Statement should be completed by the appropriate legal representative (executor, administrator, or guardian). If no legal representative has been or will be court-appointed, this section should be completed by the person who assumed responsibility for the estate or beneficiary.

3. Return both the Group Contract Holder Statement and the Beneficiary Statement(s) with the required documents noted below to:

The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19101

If you have any questions, please call our Group Life Claim Division at 800-524-0542 and a customer service representative will assist you.

Documents to submit to Prudential

Submit the Group Contract Holder Statement, Beneficiary Statement(s), and the following attachments:

- 1. A certified copy of the death certificate.
- 2. A copy of the employee's enrollment card, if available.
- 3. Any beneficiary changes, if applicable.
- 4. The certificate of insurance, if available.
- 5. Legal documentation of the beneficiary for the following situations:

If the beneficiary is

(a) an estate, minor, or not competent to handle financial affairs: attach a certified copy of the court order appointing the legal representative.

- (b) a trust: include a letter verifying that the trust is still in effect. If the trust is a testamentary, attach a certified copy of the will and a certified copy of the testamentary.
- (c) no longer living: include a copy of the death certificate.
- 6. If the insurance was assigned, attach a copy of the assignment and all related papers. If it is a collateral assignment, attach the assignee's statement of indebtedness.
- 7. If an accidental death claim is being filed, attach supporting information, such as a police report or newspaper clippings.
- 8. If a Business Travel Accident (BTA) claim is being filed, attach information requested in (7) together with documentation further substantiating the loss, such as a trip itinerary, travel tickets, etc.





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The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19101

Group Life Insurance Claim Form (Use for employee/member and dependent death claims)

Group Insuranc	e Contract Holder Statement To be completed by Employer/Plan Administrator. Please complete all five sections.
Deceased's Information	First Name MI Last Name Social Security Number Date of Birth (MM DD YYYY) Date of Death (MM DD YYYY) Gender Relationship to Employee Male Female Employee Spouse Child Other Did employee have accidental death coverage? Date of Accident (MM DD YYYY) State of Accident Yes No Last Name
Employee/ Member Information	First Name MI Last Name
Employer/ Association Information	Employer's Name Street Suite City State ZIP Code Telephone Number



Deceased's Social Security Number										

Insurance Coverages	C	omp	olete	e on	ly th	ne c	over	age	e(s) th	at a	ppl	y to	this	s cla	ıim.																									
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Travel Accidental Death	L		\perp	\perp						L					╛				_].				L						L						L	\perp	\perp			╛
	\$	Salary Amount on Last Day Worked \$																																						
		Has insurance percentage increased in last two years? Yes No If yes, provide date (MM DD YYYY):																																						
	Was evidence of insurability required to secure current coverage? Is there contributory insurance? Is there contributory Yes No Date Last Premium Paid (MM DD YYYY))																														
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Deceased's Social Security Number												
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Payment Information

GL.98.50 Standard

Ed. 6/2003

Mail payment to: Employer at address Beneficiary(ies) at address(es) listed below	Other (please specify in cover letter)
Please provide the following information about the beneficiary(ies). If the claim is for a depende	nt child, list the employee as beneficiary.
Name of Beneficiary	Date of Birth (MM DD YYYY)
Social Security Number Relationship to Deceased	Telephone Number
Residence: Street	Apt.
City State ZIP Code	
State Zin sode	
N	D ((P) 1 (
Name of Beneficiary	Date of Birth (MM DD YYYY)
Social Security Number Relationship to Deceased	Telephone Number
Residence: Street	Apt.
City State ZIP Code	
Name of Beneficiary	Date of Birth (MM DD YYYY)
a.lio S. Bolioloka,	
Social Security Number Relationship to Deceased	Telephone Number
Ticiationship to beceased	Telephone Number
Residence: Street	Apt.
City State ZIP Code	
Completed by (name of representative of the employer or benefit administrator)	
Please print	
or type name	
	Date (MM DD YYYY)
Signature X	
-	

Page 4 of 8



Deceased's Social Security Number										

Payment Information Continued

Mail payment to:	Employer at address Beneficiary(ies) at address(es) listed below	Other (please specify in cover letter)
Please provide the fe	ollowing information about the beneficiary(ies). If the claim is for a dependen	nt child, list the employee as beneficiary.
Name of Beneficiary		Date of Birth (MM DD YYYY)
Social Security Num	ber Relationship to Deceased	Telephone Number
Residence: Street		Apt.
City	State ZIP Code	
Name of Beneficiary		Date of Birth (MM DD YYYY)
Social Security Num	ber Relationship to Deceased	Telephone Number
Social occurry warm	Tiolationship to beccased	Telephone Warnaci
Residence: Street		Apt.
City	State ZIP Code	
Name of Beneficiary		Date of Birth (MM DD YYYY)
Social Security Num	ber Relationship to Deceased	Telephone Number
Residence: Street		Apt.
City	State ZIP Code	
	of representative of the employer or benefit administrator)	
Please print or type name		
		Date (MM DD YYYY)
Signature X		



Beneficiary Statement

Each beneficiary should complete Sections 1, 2, and 3. If accidental death or Business Travel Accident benefits are being claimed, Section 4 should also be completed. Return the form to the deceased's Employer/Plan Administrator.

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1	Deceased's	First Name MI Last Name												
	Information													
		Social Security Number												
2														
	Beneficiary's	First Name MI Last Name												
	Information													
		Street Suite												
		City State ZIP Code												
		Telephone Number Date of Birth (MM DD YYYY)												
3	T													
	Taxpayer Identification	Prudential requires your Taxpayer Identification Number. The Taxpayer Identification Number is either the Social Security Number or the Employer Identification Number. If you:												
	Number and	are an individual, your Taxpayer Identification Number is the Social Security Number.												
	Certification	 represent a trust or estate, the Taxpayer Identification Number is its Employer Identification Number. 												
		• represent a minor, please provide the minor's Social Security Number.												
		• are applying for a Taxpayer Identification Number, please write "applied for" in the space provided.												
		TAXPAYER IDENTIFICATION NUMBER/FORM W9 CERTIFICATION:												
		Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer												
		Identification Number (Social Security Number). I further certify that the citizen/residency status I have listed on this form is my correct citizen/residency status. I am not subject to backup withholding because												
		(a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding,												
		(b) the IRS has told me that I am no longer subject to a backup withholding order, or (c) I am exempt from												
		backup withholding.												
		Social Security Number or Taxpayer Identification Number of beneficiary												
		Check here only if you are subject to backup withholding:												
		I have been notified by the Internal Revenue Service that I am subject to backup withholding due to underreporting of interest or dividends.												
		I am not a U.S. person (including resident alien). I am a citizen of (Attach completed IRS Form W-8BEN, if applicable)												
		The Internal Revenue Service does not require your consent to any provision of this document other												
		than the certifications required to avoid backup withholding.												
		Date (MM DD YYYY)												
		X												
		Signature												



Beneficiary Statement	If filing for an accidental death claim, please complete Section 4 belo	W.
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Authorization Name of Insured: for Release of First Name MI Last Name Information to Prudential Insurance Date of Birth (MM DD YYYY) Company This Authorization I authorize any health plan, physician, health care professional, hospital, clinic is intended to other health care provider that has provided treatment, payment or services p comply with the First Name MI Last Name HIPAA Privacy Rule Print Name of Deceased or Patient or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire med and any other health information concerning me (him/her) to the Prudential In and its agents, employees, and representatives. This includes information or Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. The diagnosis and treatment of mental illness and the use of alcohol, drugs, and to I authorize all non-health organizations, any insurance company, employer, or information, data or records relating to credit, financial, earnings, travel, activ Unless limits* are shown below, this form pertains to all of the records liste By my signature below, I acknowledge that any agreements I (he/she) have health information do not apply to this authorization and I instruct My Provide entire medical record without restriction. This information is to be disclosed under this Authorization so that Prudential fulfill responsibility for coverage and provision of benefits, 2) obtain reinsuran other legally permissible activities that relate to any coverage I (he/she) have (This authorization shall remain in force for 24 months following the date of r is in force, except to the extent that state law imposes a shorter duration. A the original. I understand that I have the right to revoke this authorization in request for revocation to Prudential at: PO Box 8517, Philadelphia, PA 19101 effective to the extent that any of My Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign this authorization to release my complete medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization. *Limits, if any:

NOTICE TO MONTANA RESIDENTS: You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.



Signature of Insured/Patient or Personal Representative

Date (MM DD YYYY)

Description of Personal Representative's Authority or Relationship to Patient



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WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

CALIFORNIA RESIDENTS— For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY RESIDENTS— Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW YORK RESIDENTS— Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS— Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals, for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.